28533 Spring Trails Ridge Suite 220
Spring, Tx 77386
(832) 791-4150 Office
(832) 764-7656 Fax

Dear Sleep Tight/Humble Dreams Sleep Study Patient,

Thank you for allowing Sleep Tight/Humble Dreams Center the privilege to provide your sleep study as requested by your physician. Included with this document is a Patient Information form, and a questionnaire, as well as a list of the "do's and don'ts" pertaining to the sleep study. Also included is a map of our location.

You should plan on arriving for your study at 8:30 pm. Your study will last until 6:00 am the following morning, unless specifically requested otherwise. If you have any questions about the instructions, information or questionnaires, please don't hesitate to call us during office hours, or if **after office hours** Please call 713-499-0358.

Here are your follow up instructions to help guide you through the process of events to come, what you can expect and what your responsibilities are as the patient to do:

For your first (diagnostic) sleep lab study:

1. Our Registered Sleep Technologists and Board Certified Sleep Physicians will score and read your study within a few business days.
2. We will then fax the sleep report to your ordering / referring physician.
3. As soon as your report has been faxed to your doctor we will call you to let you know if you need to come back for a second (titration) sleep study with a CPAP/BIPAP machine.
4. At that time we will let you know if you have a copay for the second study, if your insurance has approved the study and schedule you for the second night study (if you have not already been scheduled).

For the second (titration) sleep study:

1. Our Registered Sleep Technologists and Board Certified Sleep Physicians will score and read your study within a few business days.
2. We will fax the second night study to your ordering physician.
3. We will call you as soon as your report has been faxed to your physician.

4. Depending on your doctor that referred you to our facility, you will be instructed to do one of the following:
    - We will call and schedule you an appointment with a Sleep Physician in our facility to go over your report and write a prescription for your equipment. After we have your prescription we will send it out to a DME (durable medical equipment) company who will contact you about setting you up and we will also give you their contact information.
    OR
    - We will call and give you the name and information on a Sleep Physician to follow up with and you will have to make an appointment at their office. After the physician sees you in their office, they will send us your prescription and we will send the order out to a DME company. Someone from our office will call you the same day your prescription is sent out to let you know which company will set you up and can give you their information.

Please be aware, that in some rare cases, patients that have more severe sleep issues MAY need to come in for a third or fourth night study depending on your diagnosis and severity of your sleep issues to find the best therapeutic treatment plan for your diagnosis.

(Your referring physician MAY prescribe you CPAP/BIPAP RX but be aware that ALL patients are required to follow up with a sleep physician within 30-90 days of receiving your CPAP machine so they are able to download your equipment and send to your insurance provider. If you do not follow up with a sleep physician and submit your compliance report to your insurance company, they may take the equipment back and you will not be able to get supplies covered by your insurance in the future when necessary OR in some cases even have to start the entire process all over again from start to finish. This is why we recommend you follow up with a sleep physician after your studies are complete and get your PAP therapy RX from them to avoid these types of issues.

After you have received your CPAP/BIPAP equipment, you should follow up with your sleep physician within 30-90 days. At this appointment you will need to bring your machine with you for your doctor to download the data from your equipment to make sure your pressure is adequate and therapeutic. Also, the insurance company will request a compliance report from your doctor showing you have been using the machine so that you are able to get new supplies (mask, hose and filters every 3 months).

WHAT WILL TAKE PLACE DURING YOUR STUDY:

When you arrive to the lab, with a small tour of the lab you will be escorted to your room. If you have your paperwork the tech will collect it and any copays that may be required. They will give you a little more paperwork to complete for us and you will be asked to change into your sleep attire. The tech will come in to get you set up with the wires (it will take about 30-40 minutes) so you will be ready for bed at your convenience or by 11 pm. When the study is started video monitoring will start up with the computer. This is a safety measure for you the patient and for the technician. Anytime during the study should you need anything, all you have to do is call out for the tech or knock on the table or headboard. There are intercoms in the room so the technician will be able to hear you. At the end of the study before the technician comes to get you up, your study will be ended along with the video recording. Your study will be for a minimum of 6 hours (Insurance Requirement) You will be unhooked from all the wires, and will be given a little more paperwork to complete.

THE DAY OF TESTING:

DO NOTS:

- Please do not take any naps.
- Please do not drink caffeinated beverages after 4:00 p.m.
- Please do not sleep past 9:00 a.m. on the day of your test.

DO'S:

- Eat dinner before reporting.
- Bring a list of all your medications.
- Continue to take all your medications according to your doctor's instructions.
- Bring any medications that you will need to take between the hours of 7:30 p.m. and 7:30 a.m.
- Bring your own sleepwear (No silk clothing). You may bring your own pillow if you wish. *Plan for*
- *comfort*.
- If you are on a CPAP or BIPAP machine already, bring your equipment and Interface (Mask, Pillow Circuit, Etc.) for evaluation and pressure checks.

PREPARATION FOR TESTING:

- Please **wash your hair** the night before or the morning of your study and **avoid using hair products** the day of the study. If this is not practical, please wash your hair when you arrive. Please **arrive without make-up**, if possible. If this is not practical, please wash your face to remove make-up when you arrive. Unless you have a beard, please **be clean-shaven.** If you have a beard, we can work around it, but beard stubble is very difficult to work with.
- **Hairpieces and wigs** must be removed. We must be able to get to your scalp to do the test.
- **It is best to not have dark colored or glittery nail polish on your finger nails for your test to get best results.**

GOING HOME:

- You will be awakened between 5:30 and 6:00 a.m. the next morning and you may leave as soon as you are ready to go. Checkout time is at 7:00- 8:00 a.m. at the latest.

GUESTS:

- Adult family members are welcome and encouraged to be present for the educational portion of the study. However, we do discourage anyone from staying over-night unless scheduled for a study. If you require the help of a personal care assistant due to a medical disability, we would be happy to have your PCA stay with you. Please let us know at the time of scheduling so we can accommodate your assistant with a recliner to stay in your room.

IF YOU NEED TO RESCHEDULE OR CANCEL YOUR STUDY:

- If you need to cancel or reschedule your appointment please call us at (832-791-4150). You may leave a message on voicemail if outside of normal business hours. **If you do not show up for your scheduled appointment or cancel within 24 hours of your scheduled appointment, YOU WILL BE CHARGED A $125.00 NO-SHOW FEE.**

WHEN:

- You will need to report to the sleep lab between 8:00- 8:30PM unless told otherwise. **Please do not show up any earlier**, as technicians do not get in to the lab until 7:30 pm. And they will need time to get set up for you.

WHERE:

28533 Spring Trails Ridge Suite 220
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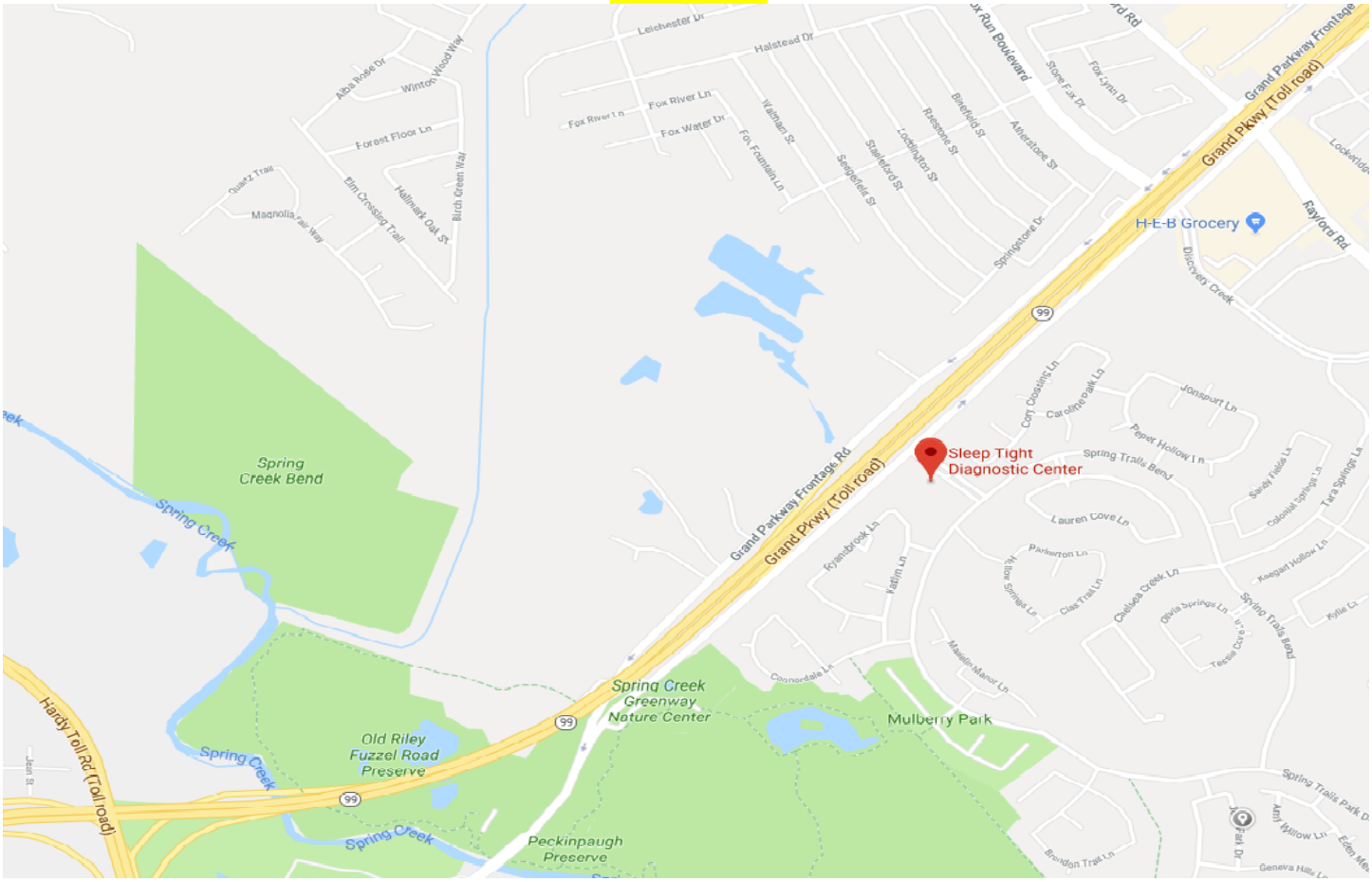
(832) 791-4150 - Phone



Please feel free to call (832) 791-4150 during office hours, or 713-499-0358 after office hours if you have any questions about your sleep study, or where to go

From Rayford Rd turn right on the 99 feeder rd. Go to the first turn around under 99 and head back to Spring Trails Ridge Rd. which will be the first road on your right. Turn and go to the first driveway on your right. Go forward to the parking lot. Our entrance is located at the door where the mailboxes are located at the end of the building on your right as you go to the parking lot. Enter that door and the elevator is on your left, exit elevator to the left to our Lab.

From Aldine Westfield Rd., Turn Right on Riley Fuzzel, Spring Trails Ridge Rd will be the first road to your right after you pass the Spring Creek Nature Center. Turn Right onto Spring Trails Ridge Rd and go to the first driveway on your right. Go forward to the parking lot. Our entrance is located at the door where the mailboxes are located at the end of the building on your right as you go to the parking lot. Enter that door and the elevator is on your left, exit elevator to the left to our Lab.

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DIAGNOSTICS AND TREATMENT SLEEP QUESTIONNAIRE

Name: _____ DOB: _____ Age: _____ Height:___ ft .____in Weight:_____lbs.

Referring Physician: _____ Neck or collar size: _____in.

1. If this is someone other than the patient filling out this form, please indicate your relationship to the patient:

   _____

2. My sleep is frequently disturbed by: (check all that apply)

□ Snoring	□ Holding Breath	□ Nasal Congestion
□ Choking /Coughing/ Gasping	□ Indigestion or Heartburn	□ Heat/Cold
□ Anxiety	□ Waking Up Feeling Paralyzed	□ Ambient Light/Noise
□ Hunger	□ Bed Partner/Children/Pets	□ Frequent Need to Urinate
□ Creeping/Crawling Feelings in Legs	□ Kicking/Twitching	□ Tossing/Turning
□ Teeth Grinding/ Jaw Pain	□ Trouble Falling/Staying Asleep	□ Sleep Walking/Talking
□ Nocturnal Enuresis (Bed Wetting)	□ Feeling tired and sleepy during the day	□ Dry Mouth/ Thirst
□ Vivid Dreams (Dreaming in Color)	□ Acting Out Dreams	□ Nightmares

3. Have you ever had a sleep study? ▫Yes ▫No

   If so, when and where? _____

4. Are you currently on CPAP therapy? ▫Yes ▫No

   If so:
   - What pressure are you presently using? _____cm
   - Does the mask fit OK? ▫Yes ▫No
   - Do you use it every night? ▫Yes ▫No

5. Have you recently lost or gained weight? ▫Yes ▫No

   If so, how much? ▫ Lost ▫ Gained _____lbs.

6. Do you smoke? ▫Yes ▫No

   If so, how much and for how long? ____Cigarettes ____Day _____Years

7. Do you consume alcoholic beverages? ▫ Yes ▫ No If so, how much?_____

8. Do you consume caffeinated beverages? ▫ Yes ▫ No If so, how much?_____

9. Please check all major medical problems:

▫ Allergies	▫ Headaches/Migraines	▫ Depression/ Anxiety	▫ Diabetes	▫ Opioid Dependence
▫ Obesity	▫ High Blood Pressure	▫ TMJ/ Bruxism	▫ Impotence	▫ Heart Disease
▫ Ulcers	▫ Reflux/GERD	▫ Fainting/Black Outs	▫ Stroke	▫ Epilepsy
▫ Asthma	▫ Arthritis	▫ Incontinence	▫ Cancer	▫ Parkinson's
▫ COPD	▫ Thyroid Condition	▫ Kidney Trouble	▫ Bronchitis	▫ Fibromyalgia

Please list any illness not listed above:

_____

10. Please list ALL medications you take including over the counter: (Circle any medications you take before bed)

_____

11. Are you allergic to any drugs? ▫ Yes ▫ No If yes, please list:

_____

12. Have you had nasal or sinus surgery? ▫ Yes ▫ No If yes, please describe:

_____

YOUR SLEEP PATTERNS:

1. What time do you usually go to bed? Weekdays: _____:_____ Weekends: _____:_____
2. What time do you usually wake up? Weekdays: _____:_____ Weekends: _____:_____
3. Do you have Insomnia? ▫ Yes ▫ No
4. Do you take naps during the day? ▫ Yes ▫ No
   If yes, when, how many, and for how long?

   _____
5. Do you suffer from pain that interferes with your sleep? ▫ Yes ▫ No
   If so, please explain:

   _____
6. Have you been told that your snoring is (circle the appropriate response):

   Light Moderate Loud Very Loud
7. Does it disturb your bed partner? ▫ Yes ▫ No
8. Has anyone told you that you stop breathing in your sleep? ▫ Yes ▫ No
9. Do you feel refreshed when you wake up in the morning? ▫ Yes ▫ No
10. Do you grind your teeth together while sleeping? ▫ Yes ▫ No
11. Have you ever walked in your sleep? ▫ Yes ▫ No
    If so, at what age: _____
12. Do you have frequent nightmares? ▫ Yes ▫ No
13. Have you injured yourself or a bed partner “acting out” dreams? ▫ Yes ▫ No
    If so, please explain: _____
14. Do you experience vivid dreams upon falling asleep or waking up? ▫ Yes ▫ No
15. Have you had spells where you feel that you are unable to speak or move when you are about to fall asleep or when you are awakening? ▫ Yes ▫ No

DURING THE DAY:

1. Have you experienced sudden muscle weakness (that makes you fall or causes your knees to buckle)?

   When laughing? ▫ Yes ▫ No

When angry? ▫ Yes ▫ No

Other: _____

2. Do you feel tired during the day? ▫ Yes ▫ No
3. Are you sleepy or groggy during the day? ▫ Yes ▫ No
4. Does sleepiness interfere with your work? ▫ Yes ▫ No
5. Have you experienced sudden or uncontrollable sleep attacks? ▫ Yes ▫ No
6. Do you get sleepy while driving? ▫ Yes ▫ No

Epworth Sleepiness Scale

Instructions: Please give the answer that most accurately describes the chances of you dozing off or falling asleep in the following situations. This refers to your usual way of life in recent times.

0 - Never; 1 - Slight; 2 - Moderate; 3 - High

Sitting and Reading	
Watching Television	
Sitting Inactive in a Seminar, Theater, or Meeting	
As a Passenger in a Car for One Hour	
Lying Down to Rest in the Afternoon	
While Having a Relaxed Conversation	
Sitting Quietly After Lunch	
In a Car While Stopping at a Traffic Signal	
Total Points (Max/24)	

NEUROLOGICAL:

Have you ever been diagnosed with Epilepsy or suspect you may have had a seizure? ▫ Yes ▫ No

If so, please explain: _____

Have you ever had an electroencephalogram (EEG)? ▫ Yes ▫ No

If so, when? _____

Do you Experience:

▫ Yes	▫ No	Dizzy Spells	▫ **Yes**	▫ **No**	**Tremors/ Uncontrolled Movements**
▫ Yes	▫ No	Witnessed Staring Spells	▫ **Yes**	▫ **No**	**Headache/ Migraine**
▫ Yes	▫ No	Deja Vu	▫ **Yes**	▫ **No**	**Unsteady Gait/ Loss of Balance**
▫ Yes	▫ No	Feeling Weak	▫ **Yes**	▫ **No**	**Convulsions/Seizures**
▫ Yes	▫ No	Numbness/Tingling			

▫ Other: _____

Please note, for liability purposes, if you have questions regarding your sleep study results, our staff cannot give you a diagnosis or give you your results. However, if you have seen your physician to get your results and feel like you have more questions or do not understand the reports you were given, feel free to contact us at 832-791-4150 and ask for Rob (our lab and sleep tech manager). He is in the sleep lab Monday through Friday and he can try to help explain any questions you may have in further detail for you. He will only be able to do this if we can confirm you have followed up with your physician first to get your diagnosis. You can do this by asking your physician's office to fax us your follow up progress note as confirmation you have been seen. Our fax number is 832-764-7656.

X_____ _____

Signature Date

Authorization for Treatment

Name: _____ Date: _____
(Print patient full name)

Authorization for Treatment

I hereby voluntarily consent to medical care for diagnostic procedures and medical treatment as ordered by my physician, his/her assistants or designees, as may be necessary in his/her judgment. I acknowledge that no guarantees have been made as to the results of treatments or examination.

Signature of patient/guardian_____ Date:_____

Assignment of Benefits

I hereby authorize *Sleep Tight Diagnostic Center* all my rights, title and interest in the benefits payable to me by an insurance policy(ies) or benefits plan under which I am covered for services rendered by the physician. I understand that Sleep Tight Diagnostics Center maybe out of network with some insurance companies and am responsible for any remaining balances. I understand that I am responsible for all the charges not covered by the assignment and hereby promise to pay the remaining balance.

Signature of patient/guardian_____ Date:_____

Authorization for Release of Information

I authorize *Sleep Tight Diagnostic Center* to request or release to or from the insurance carrier, Social Security Administration, third party administrators, referring physicians, or any other party that may be liable for all or part of medical charges information as may be necessary for the purpose of enabling the determination of benefits available to the patient for the services rendered during the period of care.

Signature of patient/guardian_____ Date:_____

Authorization for the Video Monitoring and Photograph

I authorize *Sleep Tight Diagnostic Center* to monitor my sleep session via video camera and video monitor and to record the sleep session on videotape for the purpose of diagnostic observation of the polysomnographic study that has been ordered by my physician. I understand that any videotape will be destroyed after my polysomnographic study has been interpreted and the clinical report has been generated. In addition, I authorize *Sleep Tight Diagnostic Center* to take still photographs of me for the purpose of display on the clinical report of the result of my polysomnographic study. The still photographs will be stored digitally for a maximum of 1 year and then destroyed.

Signature of patient/guardian_____ Date:_____

Medical Records Release Authorization

I,_____ hereby authorize:

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(Please check off the following items)

- ☐ Sleep Study Reports
- ☐ Any progress notes from physicians
- ☐ Patient questionnaire forms
- ☐ Demographics/ insurance information
- ☐ Prescriptions for DME (durable Medical Equipment)
- ☐ Any billing information or receipts

To give the following items (as checked above) to the following people:

Person name	relationship
Person name	relationship
Person name	relationship
Person name	relationship

X_____ _____

Signature Date

I fully understand that if medical records are requested by mail, email or fax that Sleep Tight Diagnostics Center is not responsible for your personal and/or medical information when disclosed to a third party and the information may no longer be protected by the federal or state laws and may be redisclosed by the person or entity that receives this information.

PATIENT INFORMATION

Last Name:_____ First Name:_____ MI:___

Home Phone:_____ Cell Phone_____

Address:_____

City:_____ State:_____ Zip Code:_____

Sex:_____ Date of Birth:_____

PRIMARY INSURANCE

Name of Insured:_____ Relation to Patient:_____

Insurance Name:_____ Insurance Phone:_____

Member ID Number:_____ Group Number:_____

SECONDARY INSURANCE

Name of Insured:_____ Relation to Patient:_____

Insurance Name:_____ Insurance Phone:_____

Member ID Number:_____ Group Number:_____

- I hereby authorize payment of medical benefits billed to my insurance to Sleep Tight Diagnostics Center (STDC) unless otherwise informed.
- I hereby accept responsibility to pay for any service(s) provided to me that are not covered by my insurance.
- I agree to pay all co-payments, coinsurance and deductibles at the time service is rendered.

_____ _____

Signature of Patient or Guardian ***Date***